

Improving the Medicaid Application Workflow Process

Teangela E. Wallace

Department of Health and Human Services

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My project topic is improving the Medicaid Application Workflow Process. Applications can be processed more timely and more accurately, if they are processed by one eligibility worker from start to finish. This issue is important in my workplace because with the current process, so many hands are touching the same application that it is taking more than forty-five days which is the standard processing time ("South Carolina Department of Health and Human Services," 2017) to process an application. The error rates are high due to so many workers handling one case. Our goal in the eligibility unit is to process cases as accurately as possible within 45 days. To cause completion rates to be high and eligibility errors to be low, one person should process the case from start to finish. Right now when a worker picks up a case that has already been started, the worker has to take time to research the case to see what has already been done and to make sure that no other information is needed in order to process the case. Some cases that are pulled to be processed do not have good documentation, so it can take a worker fifteen minutes or longer to research the case to figure out what has been done and what needs to be done to it. The time used to research the case could have been used to process it.

I chose this topic in order to better accomplish the mission of the Department of Health and Human Services which is to purchase the most health for those in need at the least cost to taxpayers. This can be done if the eligibility worker can process the case from start to finish. Some clients are receiving benefits that they are not qualified for and some are not receiving benefits when they should be. This is not accomplishing the mission of our agency. When applications are processed by one eligibility worker and errors are found, management staff can

have conversations with that particular worker and send him or her to any training that is needed to minimize errors because all workers are not trained the same. When applications are processed by more than one worker, it is hard to find out who actually made the error. You have to take time to look at all data that was placed in the eligibility system and look at the history of when the data was entered to see who entered that piece of data to determine who made the error. It would be easy for our customers as well because they do not have to worry about getting several different notices stating that they need to turn in additional information in order to receive benefits. This frustrates clients and slows down the application process.

Data Collection

I work with the Local Eligibility Processing unit. Our job is to provide excellent customer service to our customers and to process MAGI and Non-MAGI applications. Modified Adjusted Gross Income (MAGI) category consists of Medicaid for families, pregnant women, and children and the Non-MAGI category consists of our Aged (clients aged sixty-five or older), Blind, and Disabled clients ("South Carolina Department of Health and Human Services," 2017). The goal of my data collection was to see whether there were less errors and shorter processing times when one eligibility worker processed those types of case compared to when more than one eligibility worker processed the cases. I gathered the data from completing supervisor case reviews, reports from the PathOs system, and reports from the Medicaid Eligibility Determination System (MEDS) Query Report. PathOs is the system that gives the eligibility worker the case that they need to process. It provides real-time data and identifies the volume of work that is completed and how quickly that work is being completed ("South Carolina Department of Health and Human Services," 2017). The Medicaid Eligibility Determination

System (MEDS) is the system where Non-MAGI applications are processed and a few MAGI applications are processed. A majority of the MAGI cases are processed in the Cúram system, which is a software solution that enables governments to provide citizens a single point of access to all social programs and services for which they are eligible (“IBM-Social Programs,” 2017). We also have a system called OnBase where our applications and other documents are stored once they are scanned. It took the place of paper case files. OnBase was implemented in the county where I work in May 2013. When OnBase was implemented, we no longer had caseloads and it was possible for more than one worker to work on one case.

Data Analysis

I did a supervisor case review on 143 cases. Out of these cases, ninety-seven (68%) were correct and forty-six (32%) were incorrect. Out of the forty-six cases that were incorrect, twenty-nine (63%) of them had been touched by more than one worker before they were completed (see Figure 1). The types of errors that I found were as follows: (1) Documentation was not completed to state what actions had been completed by the eligibility worker, (2) Some information was requested that were already on file or that could have been received electronically, and (3) Collateral calls were not made in order to get the needed information. These errors can prolong the processing times. If the error is due to no documentation on file, the next eligibility worker who picks up the case would have to spend time looking through every document on file to see what has already been done to the case and to see what needs to be done to the case. This error can also cause error number two, information to be requested that is already on file. When processing cases, we were trained to use the Income and Resource Matrices (see Appendix 1 and Appendix 2) to help to get applications processed at first touch.

This method is called the One-and-Done approach. This is double work. Collateral calls can eliminate some of the errors because you are able to get information from the customer at first touch and can process the case without handing it off to another worker to finish processing it. According to the PathOs report ("PathOs," 2017) from December 2016, the average processing time was 53 days. This is with more than one eligibility worker processing a case. According to the MEDS Query Report ("MEDS," 2017), the average processing time from December 2012 (when one eligibility worker processed a case) was 26 days and from December 2016 (when more than one eligibility worker processed a case) was 58 (see Figure 2).

Implementation Plan

To implement the plan, the eligibility workers would continue to use the systems that we currently have. The Agency will not have to invest in a new system so it will not be a big cost to implement it. The only system that will be affected by this change is the PathOs system. Currently, the eligibility workers can choose one task when processing a case: Approved, Denied, Finish Later, Pend, or No Contact. For the plan that I would like to implement to work, eligibility workers would need to be able to choose both Pend and Finish Later when more information is needed for a case. When a case is placed in Finish Later currently, the case is assigned to the worker that chose this task and the worker and the supervisor can see those cases. The pend cases disappear from the worker's working pathway and the case is completed by another worker when the information is returned. Finish Later cases are monitored daily by the supervisor to make sure that they are processed timely. Most of the time, the case is placed in Finish Later when the eligibility worker needs help from the Help Desk to finish the process or if it's the end of the day and the worker does not have enough time to finish it. Finish Later

also allows the worker to type a reason as to why the case was placed there. With my plan, when Pend and Finish Later are chosen together, the pended cases would be monitored also and when the needed information is scanned into OnBase or the deadline has passed for the information to be received (fifteen days from the date of request), then the worker who started on the case can finish it instead of it being handed off to another worker.

In the current application process, the customer completes the application. The completed application is given to the administrative specialist to look over to make sure that all of the questions are complete and that the application is signed. If everything is complete, the administrative specialist scans the application into OnBase and enters the case in PathOs for an eligibility worker to pull and process. The eligibility worker pulls the application from PathOs and OnBase and calls the client to his or her office. The worker sees if any verifications (income and/or resources) are needed. If everything is on file, the worker can process the case and document his/her findings on the documentation template. The eligibility worker would then choose Approve or Deny in OnBase and in PathOs. If verification is needed and the customer is in the office or is not in the office with him/her, the worker can make a collateral call or use electronic sources to get the needed verification. When verification cannot be received by those methods, then a checklist would have to be given or mailed to the client to request the information. The eligibility worker would complete the documentation template stating what information was requested and what information is already on file. The task chosen in OnBase would be follow up which means the same as pend and the task chosen in PathOs would be pend. When the information is returned by the customer, it is scanned into OnBase and the next available worker will process it and it is usually a different worker. If the previous worker

put detailed notes on the documentation template, then the case may not take long to process, but if there are no notes or not enough information to tell what has already been done to the case, it can take a lot of time to process. It's almost like you're starting from the beginning trying to figure out what needs to be done to the case. If the information is not returned, the case shows up in PathOs for the next available worker to deny the case. (See Figure 3).

In the improved method, everything will remain the same except for the procedure to follow when additional information is needed (See figure 4). Instead of choosing Pend as the task in PathOs, the worker will be able to choose Pend and Finish Later. Our Agency heads would have to talk with PathOs Support to see if it would be possible to set the system up for those two tasks to be chosen at the same time. When they are chosen together, the worker will be able to put a reason why the case is there such as, "Customer's check stubs are needed and are due back by February 17, 2017." When the supervisor and eligibility worker sees this note on February 17th, they will know to go ahead and take action on the case. When it is time for the case to be reviewed the next year, then a new eligibility worker can process the case using the new method.

Timeframes and Cost

As I mentioned earlier, since a new computer system will not be needed to accomplish the goal of the new plan, I would not think that it would cost a lot of money to implement it. We would need to add a feature to the PathOs system to be able to choose Pend and Finish Later together. It may be possible that this feature is already on the system and just needs to be activated. It would not take more time that it already does to process cases. It may even be

faster because everyone works differently, but everyone understands his/her own documentation and work. The number of staff would remain the same so there would not be a need to decrease or increase staff to do this process.

Potential Obstacles and Methods to Overcome Them

One obstacle that we may run into is not being able to add the feature to PathOs to choose two tasks at the same time. A solution to this problem would be to communicate with PathOs Support to see if the system currently has a feature on it that may work the same way as having two tasks chosen. Sometimes systems can be upgraded or additional features can be activated to do more functions.

Another obstacle is that the eligibility worker and/or supervisor may not timely monitor the cases that are in Finish Later. A solution to this problem would be to have an alert on the PathOs system when the worker and the supervisor signs in reminding them that they have a task to complete. Another solution would be to have the PathOs system to send the worker and supervisor an email stating that a task needs to be completed.

Communication with Key Stakeholders and Integration into Standard Operating Procedures

To communicate my ideas to try to get the process implemented, I would first arrange to meet with my immediate supervisor to get his feedback and make any revisions to my proposal. Once the proposal is approved by him, then I would share my proposal and data with the key stakeholders and Agency heads with my immediate supervisor present. If they approve it, I would do a pilot with my staff of seven eligibility workers for sixty to ninety days. I would monitor the processing time from the time that the eligibility worker pended the case to the

time that the information was returned by the customer and the time that the case was completed. I would also conduct supervisor reviews once a week by randomly pulling one case from each worker to check for eligibility errors. At the end of each month, I would check the processing times. If the processing time and error rates are lower or about the same as they were before the plan was implemented, then I would feel that the plan is successful. If the processing times and error rates are higher than before, then I would say that the new method is not successful.

Summary and Recommendations

In conclusion, processing times and error rates would be lower if one worker can process an application from start to finish. I took a poll of twelve workers asking them the question, "Do you prefer to process a case from start to finish or do you like the process that we currently have?" They all stated that they would prefer to process a case from start to finish and their reason for the answer was that everyone process cases and document differently and that it takes time to try to figure out what has already been done to a case when you were not the one who started it. From my data, you can see that the cases that had errors were the ones that were mostly touched by more than one worker. I recommend that one worker process the application from start to finish because it is less time consuming and will cause less errors because everyone is unique in how they do their work.

Figure 1

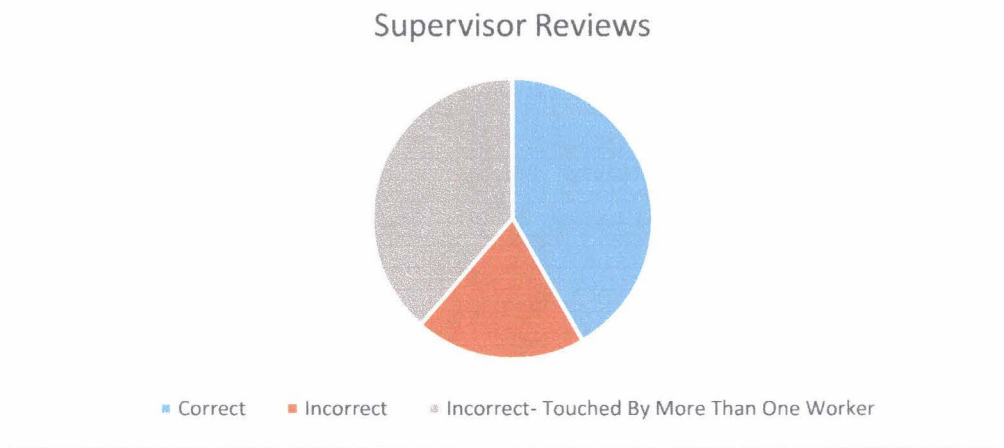
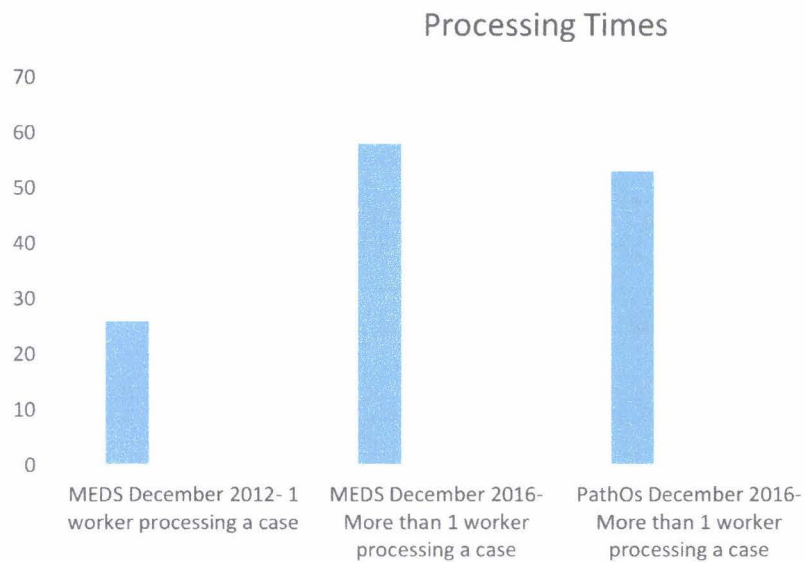


Figure 2



****Chart gives the processing times in days based on data from the MEDS Query Report and the PathOS report. We weren't using PathOs when workers had a caseload and that's the reason data from PathOs from 2012 is not available.**

Appendix 1 ("South Carolina Department of Health and Human Services," 2017).

Non-Financial and Income Verification Matrix

(Eff. 08/01/15)

		Acceptable Sources Only one data source is needed to verify an element	
		Primary Data Sources (If unable to verify, use a Secondary Source)	Secondary Data Sources (Not all data sources are listed)
Non-Financial	Citizenship	<ul style="list-style-type: none"> SVES Federal Hub (ACCESS) VCME or DMV 	<ul style="list-style-type: none"> Passport Certificate of Naturalization Birth Certificate
	Identity	<ul style="list-style-type: none"> SVES Federal Hub (ACCESS) VCME or DMV 	<ul style="list-style-type: none"> Passport Certificate of Naturalization Driver's License
	Social Security Number (SSN)	<ul style="list-style-type: none"> SVES BENDEX Federal Hub (ACCESS) 	<ul style="list-style-type: none"> Social Security Card Social Security Letter SS-5
	Age/Date of Birth	<ul style="list-style-type: none"> SVES BENDEX Federal Hub (ACCESS) 	<ul style="list-style-type: none"> Birth Certificate Driver's License
	Lawful Presence (Alien Status, Lawful Permanent Resident)	<ul style="list-style-type: none"> SAVE Federal Hub (ACCESS) SVES (40 Work Quarters) 	<ul style="list-style-type: none"> USCIS Document
	Residency	Client Statement	
	Out-of-State Benefits	Client Statement	
	Marital Status	Client Statement	
	Relationship	Client Statement	
	Household Composition/ Tax Filing Status	Client Statement	
Income	If total reported income is under \$300, the client's statement is accepted as verification		
	Unearned Income	<ul style="list-style-type: none"> BENDEX SDX UCB State Retirement System 	<ul style="list-style-type: none"> Collateral Call Award Letter Check Stub DHHS Verification Forms
	Earned	<ul style="list-style-type: none"> Wage Match WorkNumber VerifyDirect CHIP 	<ul style="list-style-type: none"> Collateral Call Check Stub DHHS Form 1245 or other written statement from employer
	Self-Employment	<ul style="list-style-type: none"> Tax Return 	
	Contributions	Client Statement	
	Pregnancy (Pregnant Woman)	Client Statement	
Categorical Specific	School Attendance	Client Statement	

	(If the only Qualifying Child for a PCR is Age 18)		
	Disability (Non-MAGI with Applicant under age 65)	<ul style="list-style-type: none"> • BENDEX • SDX 	<ul style="list-style-type: none"> • SSA/SSI Award Letter • MAO99
	Electronic Source	Client Statement	Hard Copy

Appendix 2 ("South Carolina Department of Health and Human Services," 2017).

Resource Verification Matrix

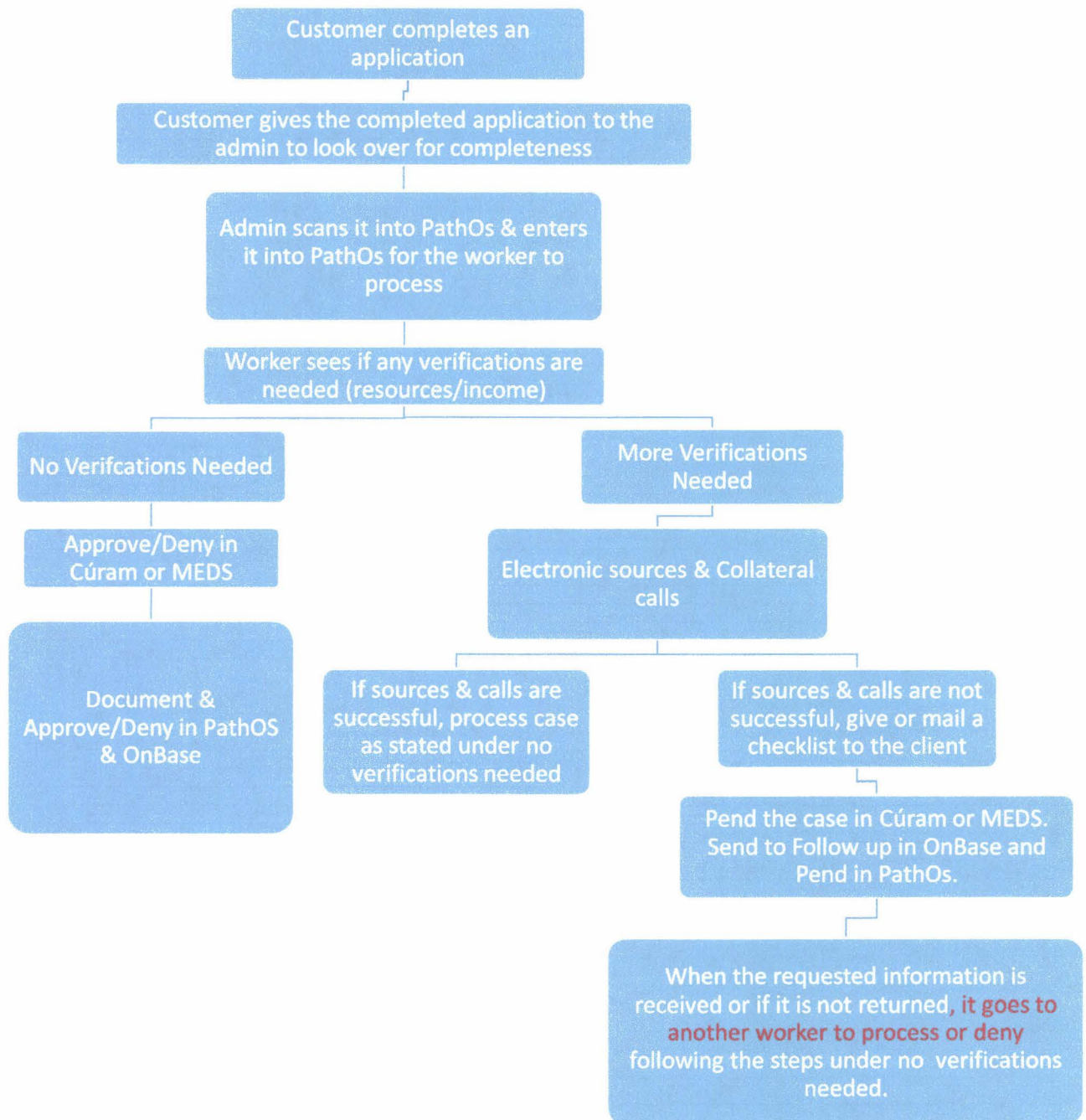
(Eff. 09/01/16)

		Acceptable Sources Only consider resources for non-MAGI programs	
Resource		Verification Sources	Instruction
Bank	Checking Account Savings Account Certificate of Deposit	<ul style="list-style-type: none"> • Documented call to Financial Institution • Asset Verification System (AVS) • Bank Statement • Account Information from Bank website 	<ul style="list-style-type: none"> • Verify: <ul style="list-style-type: none"> ○ Name of Bank ○ Account Number ○ Account Balance • Obtain balance for month of application • Obtain balance for each Retroactive month
	IRA, 401-K, Retirement Account	<ul style="list-style-type: none"> • Documented call to Financial Institution • Asset Verification System (AVS). Does not include brokerage firms • Financial Institution Statement 	<ul style="list-style-type: none"> • Verify: <ul style="list-style-type: none"> ○ Name of Institution ○ Account Number ○ Account Balance
	DirectExpress (Direct deposit account for U.S. government benefits)	<ul style="list-style-type: none"> • Client Statement 	<ul style="list-style-type: none"> • Accept client statement of account balance
Property	Homestead Property	<ul style="list-style-type: none"> • County Tax Assessor <ul style="list-style-type: none"> ○ Use county website if available ○ Send DHHS Form 1255 if the county does not have property records online • Property Tax Notice 	<ul style="list-style-type: none"> • Verify if the client alleges property: <ul style="list-style-type: none"> ○ Owner(s) ○ Location/Address ○ Map/block/parcel number ○ Value • Accept client statement if no real property is alleged*
	Non-Homestead Property		

*Exception: Long Term Care

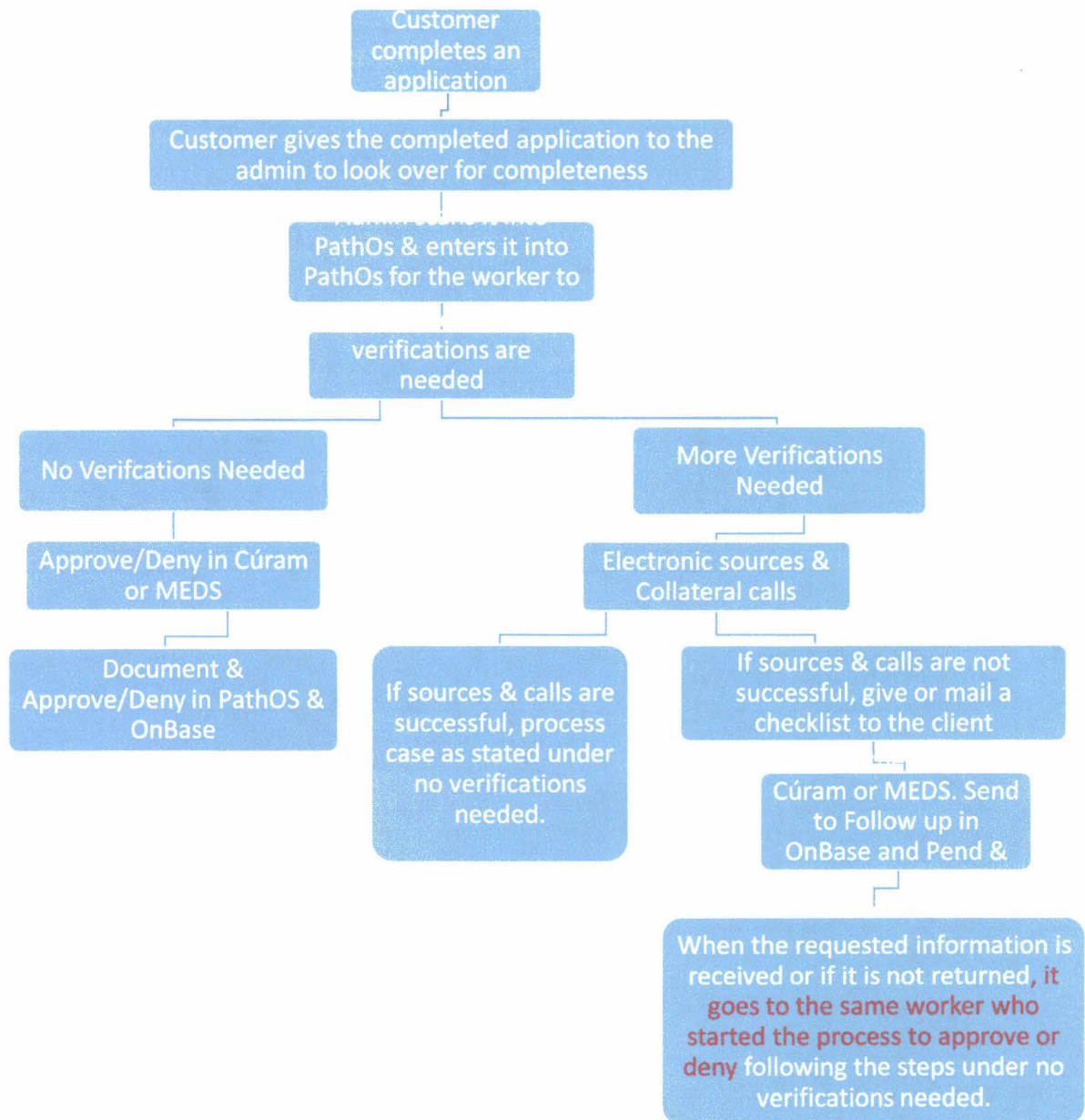
		Acceptable Sources Only consider resources for non-MAGI programs	
	Resource	Verification Sources	Instruction
	Vehicle	<ul style="list-style-type: none"> • County Tax Assessor <ul style="list-style-type: none"> ○ Use county website if available ○ Send DHHS Form 1255 if the county does not have property records online • Property Tax Notice • DMV Webtool 	<ul style="list-style-type: none"> • Accept client statement if only one or two vehicles are alleged • Verify if the client alleges more than two vehicles <ul style="list-style-type: none"> ○ Owner(s) ○ Make and Model ○ Value • Accept client statement if no vehicles are alleged
Life Insurance	Life Insurance Policy (Do not verify term life insurance provided through employment)	<ul style="list-style-type: none"> • Documented call or written statement by agent • Documented call to insurance company (automated system or call center) • Copy of policy • DHHS Form 1280 	<ul style="list-style-type: none"> • Items to verify if client alleges having life insurance: <ul style="list-style-type: none"> ○ Name of Company ○ Policy Number ○ Type – Whole or Term ○ Face Value ○ Dividends, if any ○ If total face value of all policies for each insured person is greater than \$10,000, verify the Cash value • Accept client statement if no insurance is alleged

Figure 3- Current Medicaid Application Process



****When it is time for the review (usually the next year), another worker will process the case following these same steps.**

Figure 4- Improved Medicaid Application Process



****When it is time for the review (usually the next year), another worker will process the case following these same steps.**

References

IBM-Social Programs- Cúram Universal Access. (Retrieved January 2017).

<http://www-03.ibm.com/software/products/en/universal-access>.

MEDS Query Report. (Retrieved February 2017). <http://wiki.scdhhs.gov/queryreports>.

PathOs. (Retrieved January 2017). <https://secure.epathos.com>.

South Carolina Department of Health and Human Services Medicaid Policy and Procedures

Manual. (Retrieved January 2017). <http://medsweb.scdhhs.gov/mppm/mppmtoc.htm>.